Lotus Wellspring Healthcare/ Sybil Ihrig, DACM, L.Ac., CCH
44650 Village Court, Suite 100, Palm Desert, CA 92260
Phone: 760-854-4242; email: lotuswellspring@gmail.com; web: www.lotuswellspring.com

Registration Form - (Please print)

Name: _____ Birth date: _____
Height _____ Weight: _____
Home Address: _____ Home Phone: _____
_____ Cell Phone: _____
City, State, Zip: _____ Email: _____

Gender		Marital Status				# of children
Male	Female	Single	Married	Divorced	Widowed	
☐	☐	☐	☐	☐	☐	

Occupation						
Student	Homemaker	Retired	Unemployed	Disabled	Self Employed	Other
☐	☐	☐	☐	☐	☐	☐

Employer: _____ Business/Work Address: _____
City, State, Zip: _____ Work Phone: ( )_____

Person to be contacted in case of emergency: _____Phone #: ( )_____
Address: _____

Please indicate briefly the main problem(s) for consulting a homeopath: _____
_____

How **committed** are you to solving this problem?

Strongly committed ☐ Committed ☐ Somewhat committed ☐ Lukewarm ☐ Sceptical or not committed ☐

Please provide the following information starting with the most recent. Include type of illness, month and year hospitalized, name of hospital, city and state.

1. _____
2. _____
3. _____

Please list any medications you are taking (type, dosage, frequency …)_____
_____

Medicinal Herbs, Vitamins, Teas:_____

Do you use…?	Yes	No	Amount/frequency
Coffee:	☐	☐	_____
Cigarettes:	☐	☐	_____
Alcohol:	☐	☐	_____
Other drugs:	☐	☐	Explain: _____

Allergies:_____

Medical Tests	Year	Immunizations	Year
Chest X-ray		Small Pox	
Electrocardiogram		Tetanus	
TB Test		Polio	
GI Series		Typhoid	
Kidney X-ray		Mumps, Measles	
Barium Enema		Flu	

Other X-ray _____ Other _____

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Registration Form continued (Please Print)

What are you most sensitive to (example: Noise, odors, light, pain …)? _____

Describe an ideal day in terms of weather and temperature: _____

What are your fears? _____

Do you have any hobbies? _____

(**This question women only**) What symptoms do you experience premenstrually? _____

Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams: _____

How is your energy? Is there any particular time of day when it is lower or higher? _____

How is your sexual interest/drive? _____

What do you most like to eat or crave? _____

What foods do you most dislike? _____

How is your thirst? _____

What temperature do you like fluids? _____

Are there any foods that you are sensitive to or allergic to? _____

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Registration Form. Continued…

Please place a check mark " ✓ " for any of these that apply to you

✓	Problem
	Frequent/severe headaches
	Back pains
	Neck lumps or swelling
	Loss of balance
	Dizzy spells
	Blackouts/fainting
	Wear glasses/contacts
	Blurry vision
	Eyesight worsening
	See double
	See halos or lights
	Watering eyes
	Earaches
	Hearing Difficulties
	Ringing in ears
	Noises in ears
	Dental problems
	Sore or bleeding gums
	Sore tongue
	Congested nose
	Running nose
	Sneezing spells
	Head colds
	Nosebleeds
	Sore throat
	Difficulty swallowing
	Hoarse voice
	Wheezing or gasping
	Frequent coughing
	Cough up phlegm
	Cough up blood
	Chest colds
	Rapid or skipped heart beats
	Chest pains
	Shortness of breath
	Swollen feet or ankles
	Armpits or groin swelling
	Difficulty sleeping
	Motion Sickness
	Excessive sweating
	Recurring indigestion
	Sexually transmitted diseases
	Are you ticklish-Where

✓	Problem
	Aching muscles or joints
	Swollen joints
	Back or shoulder pains
	Weakness in arms/legs
	Painful feet
	Trembling
	Numbness
	Leg cramps
	Skin problems
	Scalp problems
	Itching or burning skin
	Bruise easily
	Nervousness or anxiety
	Nervous with strangers
	Nail biting
	Difficulty making decisions
	Lack of concentration
	Loss of memory
	Lonely or depressed
	Frequent crying
	Hopeless outlook
	Difficulty relaxing
	Worry a lot
	Scary dreams or thoughts
	Feeling of desperation
	Shy or sensitive
	Dislike criticism
	Angered easily
	Annoyed by little things
	Family problems
	Problems at work
	Sexual difficulties
	Change of sexual energy
	Considered suicide
	Loss or gain in weight
	Loss of appetite
	Always hungry
	Fatigue or weariness
	Fever or chills
	Motion sickness
	Night sweats
	Hot flashes
	Warm/colder than others

✓	Problem
	Frequent belching
	Nausea
	Vomiting
	Pain in abdomen
	Bloated abdomen
	Constipation
	Loose bowels
	Black stools
	Grey or whitish stools
	Pain in rectum
	Itching rectum
	Blood with stools
	Frequent urination
	Involuntary urination
	Burning on urination
	Black or bloody urine
	Weak urine stream
	Difficulty starting urine
	Constant urge to urinate
	Women Only
	Missed period
	Menstrual problems
	Bleeding between periods
	Heavy bleeding
	Bearing down feeling
	Vaginal discharge
	Genital irritation
	Pain on intercourse
	Swelling of breasts
	Painful breasts
	# of pregnancies
	# of births
	# of miscarriages
	# of premature births
	# of caesareans
	# of abortions
	Men Only
	Burning of discharge
	Swelling on testicles
	Painful testicles

Comments or special problems:

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Registration Form - Family History

Please Place a " ✓ " in the appropriate column for any illness that you or your relatives have had

Illness	Self	Father	Mother	Brothers	Sisters	Child #1	Child #2	Child #3	Grandparents
Abnormal Periods									
Alcohol/Drugs									
Allergies									
Anemia									
Arthritis/Gout									
Asthma									
Bleeding problems									
Cancer									
Diabetes									
Eczema									
Empahsema									
Epilepsy									
Frequent Infections									
Heart Trouble									
Hepatitis									
High Blood pressure									
Kidney problems									
Mental Illness									
Migraines									
Polio									
Pneumonia									
Prostate problems									
Psoriasis									
Rheumatic Fever									
Stomach problems									
Stroke									
Thyroid problems									
Tuberculosis									
Ulcers									
Venereal Disease									
Weight problems									

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Please use this space for any additional information you would like to provide: